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OUR REF:

YOUR REF:

07 June 1996

IN STRICTEST CONFIDENCE

Dr G A Murnaghan
Director of Medical Administration
Royal Group of Hospitals and Dental
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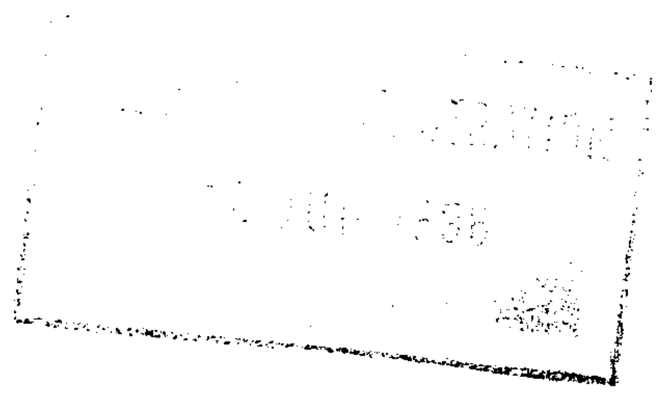

Dear Dr Murnaghan

ADAM STRAIN, DECEASED

I refer to our discussion of 5th instant with Dr Taylor and Dr Gastin in relation to the forthcoming Inquest which I believe has been listed for hearing on 18 June. The issues in this case are extremely complex, as indeed are they sensitive, and at this stage, I would not be entirely satisfied that the Inquest would in fact be completed within the course of one day's hearing.

As you know, there are a substantial number of issues contained in the Experts' reports which will require to be carefully and exhaustively examined and investigated and in that regard I have already had the benefit of very detailed instructions from Dr Taylor, and these have now been reinforced to me by Dr Gastin. I understand that Dr Sumner will in fact be in attendance to give evidence at the Inquest, and it is vital therefore that we are in a position to deal with those points in a scientific, objective and reasonable manner, the same comments apply mutatis mutandis to the points raised by Dr Alexander in his report, and in that regard, I would welcome a further statement from Dr Taylor, in which he would deal with each of the criticisms raised by the medical experts, and provide me with information in relation to the points which he would wish raised in rebuttal.

I understand that Dr Taylor has a full set of the working documentation, and whilst other witnesses will be called to give evidence, I believe it is fair to say that the main focus of the Coroner's interest will be on the anaesthetic management of this patient, particularly, in the light of the cause of death as found by Dr Armour. It is important that Dr Taylor provides express instructions in relation to his view of the cause of death which Dr Armour classifies as:-

AS – ROYAL

[redacted]

(a) Cerebral oedema
due to
(b) Dilutional hyponatraemia and impaired cerebral perfusion during renal transplant operation for chronic renal failure (congenital destructive uropathy).

This really is the starting point in relation to the instructions which I would require from Dr Taylor and if he has any difficulties in relation to accepting that cause of death, then perhaps he would let me have a note of same.

Turning to Dr Sumner's report, there are a number of veiled criticisms contained therein, and these in general terms at this moment in time I would categorise as follows:-

1. A suggestion that Dr Taylor over estimated the fluid deficit. This issue is raised in Dr Sumner's report at page 6. I will require from Dr Taylor, a precise note of the calculations which he made in relation to the fluids which would require to be given to this child, and in particular, obviously having regard to the information which was available to Dr Taylor in relation to fluid output prior to the operation. If I understand the situation correctly, Dr Taylor has indicated, that fluid output was impossible to measure prior to surgery, because the child did not have a catheter in place, and indeed this would not be a normal procedure to adopt. I will however require to have information from the case notes, which indicate in unequivocal terms, what the outputs for the child were as and when measured prior to surgery. Again turning to page 6 of Dr Sumner's report, it would appear that Dr Sumner suggests that on the basis of Dr Taylor's calculation the deficit was somewhere in the region of 150ml/hour for maintenance, whereas Dr Taylor, has indicated that a figure of around 120 is more likely. Further clarification on this point will be required.

2. At para 4 on page 7 Dr Sumner raises an issue in relation to the wisdom of taking electrolyte values prior to the child going to theatre. I know there were difficulties in obtaining blood, however I will need to have instructions as to whether the issue of electrolytes was thought about, particularly in the light of the note made by Mr Savage, and if they were thought about, then why were these tests "abandoned"?

3. CVP Readings. Dr Sumner makes great play on the fact that from the start of the procedure, the CVP Readings were rather unusual, and indeed on one occasion he refers to them as being very high. Dr Taylor in providing evidence has suggested, that the initial reading of 17 was in fact more likely to be a true reading of 12, and he has provided me with information in relation to the gradient difference which explains these two readings. Dr Sumner makes the case, that there must have been an obstruction, and that the reading of 17 was at all times correct, and this is supported by the fact that when the child was returned to the ICU, the reading returned to what might be regarded at more normal ie around 12. I will need Dr Taylor's view as to whether the "hypothesis" expounded by Dr Sumner on this point is workable, and if not, then why not? Finally on the point of the CVP Reading Dr Taylor has also provided information in relation to the catheter which was used and I would like to see one of these catheters in order that I might be in a better position to deal with the points during cross-examination. The most telling point made by Dr Taylor in this issue relates to the fact, that he has indicated that when the catheter was insitu, he could physically feel the tip of the catheter in the child's neck therefore the catheter was not at any time near to the child's heart. Is my interpretation of this point correct?

Finally, at this stage, I would wish to raise two other issues. Dr Gastin has indicated, that during the course of the procedure, Dr Taylor did not have an opportunity of accurately measuring urinary output due to the fact that the bladder had been opened early on in surgery. This point will have to be made in very trenchant terms to Dr Sumner and he will be asked what other opportunities the Anaesthetist had to measure urinary output. I suspect that Dr Sumner may fall back on the CVP issue, and it is important

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therefore that again we are in a position to deal with that point. One additional point raised by Dr Gastin related to the potential for this child, for whatever cause, to absorb fluid into the brain. I would like to see some literature which might help us in propounding such a theory, and I emphasise only as a theory, and as something that simply cannot be excluded from the present position, and in particular, that in some individuals, the physiology of such that such an occurrence can happen. Obviously if we suggest such a potential, then that of itself, would be a factor which might to some extent explain the odematus state of the brain.

In conclusion, Dr Taylor has also undertaken to provide certain documentation and in particular, Anaesthetic Monitoring Guidelines, and also a resume of the learned papers which he brought to the consultation and which deal with the issue of barbituates. I would like to see some of the equipment in use in this case, and I will liaise with your office within the course of the next few days to make the arrangements.

It will be necessary to have a further consultation with Dr Taylor, and no doubt you will make the arrangements in due course. Might I respectfully suggest that we use the Senior Medical Staff Room in view of the substantial papers which have now accumulated in this case. If any points arise in the interim please do not hesitate to contact me.

Yours sincerely

Brangam, Bagnall & Co

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